SKIP REGISTRATION 2011/2012

_____AM SESSION _____PM SESSION _____BOTH

(Students registered after August 29, 2011 may not be able to attend SKIP on the first day of school.)
Register before July 29, 2011 and the registration fee is waived.

STUDENT INFORMATION

SCHOOL_____GRADE IN SEPT. 2011_____ SEX __M___F

CHILD'S NAME_____BIRTHDATE_____
(Last)) ***(First))***
ADDRESS_____TOWN_____ZIP_____

HOME PHONE_____

PARENT/GUARDIAN INFORMATION

MOTHER'S NAME_____
(Last) ***(First)***
(If different)
MOTHER'S ADDRESS_____

WORK PHONE_____CELL _____EMAIL_____

FATHER'S NAME_____
(Last) ***(First)***
(If different)
FATHER'S ADDRESS_____

WORK PHONE_____CELL_____EMAIL_____

I understand that I am enrolling my child in the SKIP program that operates Monday-Friday, according to the SKIP calendar and that I am responsible for picking up my child by 6:00 pm. I also understand that my child and I are responsible for complying with all procedures as outlined in the Parent/Guardian Handbook. I understand and agree to all fees and payment deadlines and that the first month's tuition, registration fee and emergency information must be received with registration.

_____
Parent's Signature

AUTOMATIC MONTHLY PAYMENT
I authorize the SKIP office to charge the credit card listed below on the 15th of each month for SKIP tuition.
I understand that I may rescind this request at anytime by notifying the SKIP office.

Name as it appears on credit card_____ Visa MC Disc

Credit Card #_____Expiration Date_____

ELECTRONIC FUND TRANSFER
I authorize the SKIP office to transfer funds from the account listed below on the 15th of each month for SKIP tuition.
I understand that I may rescind this request at anytime by notifying the SKIP office.

Names as it appears on the account_____Bank Name_____

Routing #_____Account #_____

SKIP
EMERGENCY CONTACT INFORMATION

(ALL INFORMATION MUST BE COMPLETED FOR CHILD TO BEGIN SKIP)

SCHOOL_____ **GRADE IN SEPT. 2011**_____

STUDENT'S NAME_____ **SEX M____ F_____**
(Last) (First)

In an emergency, if I am unavailable, I have arranged for the following people to care for my child:

_____ _____
(Name) Telephone #

_____ _____
(Name) Telephone #

You may call our physician, if necessary:

_____ _____
(Name) Telephone #

The SKIP program provides reasonable accommodations for students with special needs. Children must have independent toileting skills. It is helpful for the staff to be aware of children whose medical, physical, learning, or social disabilities require special consideration. The accommodations are made within the framework of existing staffing ratios and program organization, but do not extend to substantial modifications in the childcare purpose, cost, or availability of appropriate supervision for all participants.

Does your child have:

1. **Any health issues that require assistance in any activities of daily living, i.e. toileting, eating, communicating? Yes____ No___**
   If yes, please list_____
1. **Any allergies to food, medication, bee stings, pollen, latex or foods? Yes____ No___**
   If yes, please list _____
   Type of reaction: Rash? Hives? Other skin condition? (Circle all that apply.)
   Take any medications/Epipen taken for allergy symptoms? Please list_____
2. **A chronic or ongoing illness (such as diabetes or asthma)? Yes____ No___**
   Use an inhaler or other prescription medicine to control asthma? Yes____ No___
3. **Any prescribed or over the counter medications that are taken on a regular basis? Yes____ No___**
   If yes, please list_____
4. **Does your child require special attention? Yes____ No___**
5. **Does your child have a one-to-one aide during the school day? Yes____ No___**
6. **Is your child in a self-contained classroom? Yes____ No___**

If you answered to yes to questions 4, 5, 6, please specify the nature of your child's needs and your recommendations in caring for them:

_____

_____

In the event of an extreme emergency, if parent, guardian or emergency contacts cannot be reached, I give permission to the school authority to arrange proper medical care at:_____

_____ **(Hospital/medical/dental facility)**

Print Name:_____ **Date:**_____

Signature: _____

Mail to: PACE/SKIP 577 Vail Road, Parsippany, NJ 07054.
973-263-7180 ext 3049 Fax: 973-263-7121